

1 1951  
WHILE I REMAIN UNFADING BLACK INK—MAKE A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH ✓

State File No. 11153

Registration District No. 384

Primary Registration District No. 53351

Registrar's No.

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town RURAL  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
West Howell Township  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
(Specify whether  
In this community,  
years, months or days)

8. (a) PRINT FULL NAME LIZZIE FREDERICK 636

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Geo. W. Frederick 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 4, 1874  
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 21 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Own Farm

12. Name Peter Boog

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Carry Wilsner

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Herbert Ryan

(b) Address West Plains, Mo. Route 2

17. (a) Burial (b) Date thereof Mar. 26, 1940  
(Burial, cremation, or removal) (City or town) (County) (State) (Year)

(c) Place: burial or cremation Howell Twp.

18. (a) Signature of funeral director Hal Thompson

(b) Address West Plains, Mo. 3000

19. (a) 3-26-40 (b) Vida W. Simon  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell  
(c) City or town RURAL (Howell Twp.)  
(If outside city or town limits, write "RURAL")  
(d) Street No. West Plains, Mo. Route 2  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25  
year 1940 hour 7 minute 45 A. M.

21. I hereby certify that I attended the deceased from  
March 13, 1940, to March 17, 1940,  
that I last saw her or alive on March 17, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Heart Failure  
Due to Conduction trouble  
(tentative)

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature R. A. Sparks (M. D. or other) \_\_\_\_\_

Address West Plains, Mo. Date signed 3/27/40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Registered Apprentice No.

working under my personal supervision.

Signed

Hal Thornburgh  
Hal Thornburgh  
Licensed Embalmer No. 3408

P. O. Address. West Plains, Mo.

RECEIVED

District Health Officer No. 5,

District File Number. 440368

Date Filed 4340

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 111537

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 384

Primary Registration District No. 5335

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town Howell  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT  
FULL NAME Lizzie Frederick

3. (b) If veteran,  
name war \_\_\_\_\_

3. (c) Social Security  
No. \_\_\_\_\_

4. Sex 7  
5. Color or race W  
6. (b) Name of husband or wife \_\_\_\_\_

6. (a) Single, widowed, married,  
divorced and  
6. (c) Age of husband, or wife, if  
alive \_\_\_\_\_ year

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

66

2

21

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5/30/1940

(Date received local registrar)

(b)

P. A. Sparks  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

20. DATE OF DEATH Month Mar day 25

year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above  
Immediate cause of death Heart failure Duration \_\_\_\_\_

Due to Mitral Stenosis

Due to \_\_\_\_\_

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature P. A. Sparks (M. D. or other) \_\_\_\_\_  
Address Went Plains Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

1940

-S-11153